FEDERAL EMPLOYEE HEALTH BENEFITS

1999 OPEN SEASON
AND
SIGNIFICANT PLAN CHANGES FOR 2000

OPEN SEASON

November 8, 1999

through

December 13, 1999

OPEN SEASON ENROLLMENT OPPORTUNITIES

- You may enroll during the open season if you are an eligible employee. If you are enrolled, you may change plans, options, or type of enrollment

- Eligible family members include spouse, dependent children under age 22 (unless they are married), and disabled children over the age of 22

- If you do not want to make a change in health plans you should not take any action at all. Just ***be sure to review how the plan changes and how your premiums WILL increase***. Do not rely solely on the premiums or comparison chart to make your decision. Carefully review the plan brochures

PLANS NOT PARTICIPATING IN 2000

- Health Assurance of Ohio, enrollment code 5X1 and 5X2
- Prudential Health Care HMO Midwest, enrollment codes AY1 and AY2; and
- HealthFirst, enrollment codes RF1 and RF2
- ***If you are enrolled in one of the plans no longer participating in the FEHB you must enroll in a different plan during the Open Season in order to continue FEHB coverage in 2000***

OPEN SEASON EFFECTIVE DATES

A new enrollment is effective the first day of the first pay period that begins in the following year and that follows a pay period during any part of which you are in pay status (January 2, 2000). A change in enrollment is effective the first day of the first pay period that begins in the following year, regardless of whether you are in pay status. When your employing office accepts a late open season enrollment or change in enrollment, it is effective retroactive to the same date that it would have been effective if it had been received on time.

ENROLLMENT METHODS

- Paper Transactions require that you submit an SF 2809 by COB December 13,1999
- Employee Express transactions require that you log on at www.employeeexpress.gov, or call Employee Express at (912) 757-3169. Employee Express transactions require that you have your Social Security Number and your PIN. To obtain a new PIN number call (912) 757-3030
  - Employee Express downloads nightly to NASA Personnel Payroll System (NPPS)
  - If you use Employee Express **DO NOT** submit a SF 2809

HOW PREMIUMS ARE CALCULATED

The Government share of the premium is equal to about 75 percent of the total premium

The old formula to determine the Government share was based on the BIG 6 formula which provided a Government contribution for eligible enrollees in any FEHB plan or Option equal to the lesser of:

(1) 60 percent of the simple average of self only or self and family enrollment charges for the highest level of benefits offered under six large plans described in law, or

(2) 75 percent of charges for the particular plan an individual elects to enroll in

HOW PREMIUMS ARE CALCULATED (continued)

The new formula provides a Government contribution equal to the lesser of:

(1) 72 percent of the amount OPM determines is the program-wide weighted average of subscription charges for the type of enrollment the individual selects, or

(2) 75 percent of the subscription charge for a particular plan. The intent of the new FEHB contribution formula known as the “Fair share” formula, is to maintain a consistent level of Government contributions, as a percent of the total program costs

IDENTIFICATION CARDS

If you make an enrollment change through Employee Express, you should receive your new enrollment cards before the effective date of the change. Always request a confirmation of your change. In case you do not receive your cards and you need medical attention, your confirmation is verification of your enrollment.

Likewise, if you file an SF 2809, the copy returned to you by OHR, is verification of your enrollment. SF-2809 changes could require 4-6 weeks for processing of enrollment cards.

HUSBAND AND WIFE ACCOUNTS

If both you and your spouse are Federal employees and there are no eligible children it may be more beneficial to have two self-only enrollments. If you are currently covered by a self and family enrollment, be sure to file a SF-2809 and cross-reference the prior coverage. This will satisfy the 5-year requirement prior to retirement.

THE 5-YEAR RULE

The 5-year law requires that you be enrolled in the FEHB Program, not a specific plan, for 5 continuous years in order to carry the coverage into retirement. This applies to regular, disability retirement, and OWCP.

AVAILABLE PLANS

Fee-For-Service (FFS)

- Managed Care plans are open to all enrollees, regardless of where you live
- Allow you to be treated by any licensed hospital
- Subject to plan deductibles and copayments
- Include Union plans

AVAILABLE PLANS (continued)

Point of Service (POS)

A product offered by an HMO or FFS plan that has features of both. In an HMO, the POS product lets you use providers who are not part of the HMO network. However, there is a greater cost associated with choosing these non-network providers. You usually pay deductibles and co-insurance that are substantially higher than the payments when you use a plan provider.

AVAILABLE PLANS (continued)

Health Maintenance Organization (HMO)

A health plan that provides care through a network of physicians and hospitals in a particular geographic or service area. Care received from a non-network provider, other than emergency care, is generally not covered.

PROGRAMWIDE CHANGES

- OPM has set a minimum co-payment of $10 for all primary care office visits
- If you have a chronic or disabling condition or are in the second or third trimester of pregnancy and your provider is leaving the PPO network at the plans request without cause, the plan will notify you
- You may continue to receive the PPO level benefits of that plan for your specialist's services for up to 90 days after you receive notice

PROGRAMWIDE CHANGES (continued)

- Most plans have increased their coverage for mental conditions and substance abuse from 50 to 70 percent
- If you are over age 50, all FEHB plans cover a screening sigmoidoscopy every 5 years. This screening is for colorectal cancer

MAJOR PLAN CHANGES

Alliance Health Benefit Plan

- Premium decrease: 10.9 percent self
  12.5 percent family
- Organ /tissue transplant and donor expenses are covered at 90 percent with a $10,000 maximum. Other benefits may apply depending on organ donation
- Cardiac Rehab-$100 PPO deductible 70 percent, non PPO $300 deductible 50 percent
- Benefits now available for smoking cession $100 after calendar year deductible has been met
- Medical Emergency: $25 copay for emergency room then 100 perccent PPO or the UCR

MAJOR PLAN CHANGES

AMERICAN POSTAL WORKER'S UNION (APWU)

- Premium increase = 8.2% self
  7.5% family

- Medicare enrollees with APWU will not pay a $5 copayment for each generic drug and a $15 copayment for each brand name drug through the Mail order program

MAJOR PLAN CHANGES

GOVERNMENT EMPLOYEES HOSPITAL ASSOCIATION BENEFIT PLAN (GEHA)

- Premium increase = 26.1% self
  26.6% family
- Copayment for doctor's visits increased from $10 to $15
- Diagnostic x-rays and lab tests are now subject to deductible and paid at 90 percent (previously paid at $100% after copayment)
- ∀ Non-PPO providers paid at 75 percent (previously 80 percent)

MAJOR PLAN CHANGES

GOVERNMENT EMPLOYEES HOSPITAL ASSOCIATION BENEFIT PLAN (GEHA) Continued

- Calendar year deductible increased $50 to $300
- Mail order Rx now $10 generic and $30 brand name drugs, up from $7 generic and $28 brand name drugs
- Medicare subscribers will now pay the copayment of $5 for generic drugs and $15 brand name drugs. The retail pharmacy copayment is $3 generic and $10 brand name for the initial Rx and first refill. Subsequent refills paid at the greater of $3 or 50 percent generic and $10 or 50 percent brand name

MAJOR PLAN CHANGES

MAIL HANDLERS BENEFIT PLAN

- High option premium increase = 16.8% self
  17.0% family
- Standard Option premium increase = 10% self; self and family
- Non-PPO providers will be paid at 70 percent if PPO providers are available and you do not use one
- Deductible added of $150 self and $450 family-high option
- Co-insurance rate for PPO providers reduced from 95 to 90 percent high option

MAJOR PLAN CHANGES

NALC HEALTH BENEFIT PLAN

- Premium increase = 8% self
  -3.2% self and family
- Plan's rate of reimbursement for PPO providers for inpatient professional care and outpatient hospital and medical care is increased to 85 percent of the negotiated rate
- Member copayments for routine services by PPO provider now range from $5 to $25 per service

MAJOR PLAN CHANGES

NALC HEALTH BENEFIT PLAN (Continued)

- Member's copayment for allergy injections by a PPO is $5
- A toll free 24 hour nurse health resource line is available
- Member copayments for PPY providers are not counted toward you catastrophic limit
- **PRIOR PLAN AUTHORIZATION IS REQUIRED FOR THE PURCHASE OF CERTAIN DRUGS. The plan may limit the maximum dosage dispensed by protocols set by the plan**

MAJOR PLAN CHANGES

POSTMASTERS BENEFIT PLAN

- Premium increases
  - High Option: 5.5% for self only
    5.2% for self and family
  - Standard Option: 4.2% self
    3.4% self and family
- The calendar year deductible for Rx filled at a participating pharmacy is reduced to a $5 copayment for generic drugs and a $12 copayment for brand name drugs

MAJOR PLAN CHANGES

POSTMASTERS BENEFIT PLAN (Continued)

- The deductible for admission to a non-PPO hospital is reduced from $600 to $250
- The $350 deductible for admission to PPO hospital is eliminated
- Catastrophic limit is reduced from $6,700 to $4,500
- Payment for covered hospital services in a PPO hospital increases to 100 percent
- PPO office visit copayment decreased to $10 and includes x-ray, lab and surgeries rendered during the visit

MAJOR PLAN CHANGES

SERVICE BENEFIT PLAN
BLUE CROSS/BLUE SHIELD

- Premium increased up to 8 percent
- Eliminated $50 prescription drug deductible for drugs obtained from retail pharmacies
- No longer waive co-payment for Rx drugs obtained through mail for Medicare members. Copayment $8-12 for generic drugs and $14-20 for brand name drugs, depending on Option

MAJOR PLAN CHANGES

SERVICE BENEFIT PLAN (continued)
BLUE CROSS/BLUE SHIELD

- No longer waive or reduce coinsurance for Rx drugs obtained from a retail pharmacy for Medicare members. All members will pay 15-25 percent at preferred retail pharmacies and 35-45 percent of average wholesale price at non preferred pharmacies
- Cardiac rehab is now covered
- Diabetes Counseling
- Sigmoidoscopy
- Immunization

MAJOR PLAN CHANGES

AETNA US HEALTHCARE

- Premium increase: 8.6% self only
  10.1% self and family
- Oral fertility drugs are now covered
- Rx $5 generic; $10 brand name and $25 non-formulary drugs, per prescription up to a 30 day supply
- 50-percent copy for drugs used to treat sexual dysfunction
- Diaphragms now require a $10 copay
- All prescriptions over 30 days must be filled through mail order
- $100 reimbursement per 24 month period for corrective eyeglasses and frames or contact lenses

MAJOR PLAN CHANGES

HEALTH MAINTENANCE PLAN (ANTHEM BC/BS)

- Premium increase will be 5 percent for self only and 3.5 percent for self and family
- Office visit copay increases to $10
- Prescription Drug benefit has changed to include a Formulary Drug program
- The days supply for the Prescription Drug mail order program has been increased to 90 days
- Diabetic supplies are now covered under the Prescription Drug benefit. Subject to copayments

MAJOR PLAN CHANGES

HMO HEALTH OHIO

- Premium increase: 13 percent self only
  21.2 percent self and family
- Behavioral health services will be delivered through the SuperMed Behavioral Health Network
- Behavioral health services include treatment for mental health, substance abuse, or chemical dependency

MAJOR PLAN CHANGES

KAISER FOUNDATION HEALTH PLAN OF OHIO

- Premium increases: 5.3 percent for self only
  12.3 percent for self and family
- The primary care office visit copay will increase from $5 to $10

MAJOR PLAN CHANGES

PRUDENTIAL HEALTHCARE HMO-MIDWEST

- Premium increases: 37.9 percent for self only
  41.1 percent for self and family
- Doctor office, short-term rehabilitative therapy, cardiac rehabilitation and urgent care center copays are increased to $10
- Prescription benefit includes a $25 non-formulary copay
- Office visit for infertility treatment increased from $5 to 30 percent of charges per office visit
- $10 office visit copay for treatment under the accidental dental injury benefit
- Vision benefit is limited to basic eye exams to determine the need for eyeglasses only

MAJOR PLAN CHANGES

SUMMACARE HEALTH PLAN

- Premium increases: 10.5 percent for self only and family
- Out of pocket maximums have been removed
- Primary Care Physician referral is no longer required for visits to a network urgent care center
- Diagnosis and treatment of infertility no longer require copayments

MAJOR PLAN CHANGES

SUPERMED HMO

- Premium increases= 30.4 percent for self
  80.2 percent for self and family
- Behavioral health services will be delivered through the SuperMed Behavioral Health Network

MAJOR PLAN CHANGES

UNITED HEALTHCARE OF OHIO, INC.

- Premium increases= 19.8 percent for self only
  18.2 percent self and family
- Drugs are dispensed in accordance with the plan's drug formulary
- Co-pay for prescription drugs increased to $10 for generic; $15 for formulary name brand drugs; and $30 for non-formulary name brand drugs
- Mail order prescription, 90 day supply $20 generic, $30 name brand formulary and $60 name brand non formulary drugs
- Medical and surgical benefit copay increased to $15 specialty care office visits
- Hospital/extended care benefit: A per hospital admission co-pay is being added. You pay $100 per hospital admission
- Under Medical and Surgical benefits, limited Benefits, coverage for cryosurgery to treat localized prostate cancer is added

TEMPORARY CONTINUATION OF COVERAGE (TCC)

- Employees who are separating, for reasons other than gross misconduct, can carry FEHB for up to 18 months paying 102 percent of the premium
- Former spouses and children turning 22, or get married can carry the FEHB for up to 36 months, paying 102 percent of the premium
- Eligible employees, former spouses and children turning 22 must contact OHR for information concerning enrollment timeframes and opportunities

PlanSmartChoice™

PlanSmartChoiceTM is a commercial product designed by Decision Innovations. OPM and the Defense Civilian Personnel Management Service believe this tool can help you choose between health plans. However, we can not certify the accuracy of the information presented. Before you decide to change your health plan, carefully read the plan's brochure, verify the premium rates, and make sure you are eligible to enroll in the plan.

http://www.opm.gov/hr/insure/html/plansmart.html